Exhibit 11

HANCOCK MEDICAL CENTER

ED-OP

REGISTRATION

STAY TYPE: 3 - E.R	SERVICE CODE - DESC: ER- ER								
PATIENT'S LEGAL NAME (L, F, MI): DAHL DOYLE	SEX: M	RACE: W	BIRTH DATE: 7/16/1967	AGE: 40	MEDICAL RECORD NO.: 002232	ADMIT DATE: 03/31/2008	ADMIT TIME: 03:06	A/R NO.: 30018094	
SOCIAL SECURITY NO.: 426-23-0795	PRIOR STAY DATE: 03/12/2008	ACCOUNT NUMBER: 30016864	PATIENT'S LEGAL ADDRESS: 6016 E MADISON RD	CITY/STATE: BAY ST LOUIS MS		WEIGHT: 000.00	AD: E	MS: S	RELIGION / CHURCH: CATHOLIC /
RESPONSIBLE PARTY: DAHL DOYLE			RESPONSIBLE PARTY'S ADDRESS: 6016 E MADISON RD	CITY/STATE: BAY ST LOUIS MS	39520	TELE: 228-467-3010			
RESPONSIBLE PARTY'S EMPLOYER: DISABLED			EMPLOYER'S ADDRESS: NA	CITY/STATE: N/A NA	99999	TELE: 999-999-9999			
SOCIAL SECURITY NO.: 426-23-0795			OCCUPATION: UNE						

PRIMARY

INS. CODE	PAYER	CLAIM PROCESSING ADDRESS	CITY / STATE	
INSURED	REL INFO			
CERTIFICATE / SSN / HIC ID NO.	GROUP NAME	INSURANCE GROUP NO.		

SECONDARY

INS. CODE	PAYER	CLAIM PROCESSING ADDRESS	CITY / STATE	
INSURED	REL INFO			
CERTIFICATE / SSN / HIC ID NO.	GROUP NAME	INSURANCE GROUP NO.		

TERTIARY

INS. CODE	PAYER	CLAIM PROCESSING ADDRESS	CITY / STATE	
INSURED	REL INFO			
CERTIFICATE / SSN / HIC ID NO.	GROUP NAME	INSURANCE GROUP NO.		

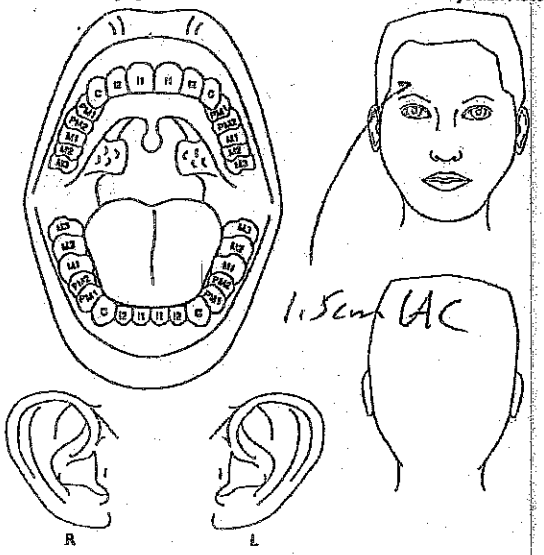
NOTIFY IN EMERGENCY: ARLENE JOHNSON	HOME TELE: 228-216-0137	WORK TELE: 000-000-0009		
ATTENDING PHYSICIAN: ZAHERI KAMRAN	PHYSICIAN CALLED	CONSULTING OTHER PHYSICIAN		
CHIEF COMPLAINT	ADMI. INITIALS: MHS			

E.R.
DAHL DOYLE
002232
03/31/08
30018094
M 40
07/16/67
ZAHERI K

MEDICAL RECORDS

4| 87342
PROC 12011

Head / Facial Injury #38 E.D. Physician Record



E.R. 30018094
DAHL DOYLE M 40
002232 07/16/67

03/31/08 ZAHERI K

Diagnostic Considerations: *circle potential diagnoses*

intracranial bleed	concussion	blowout fx
subdural hematoma	closed head trauma	facial fx
epidural hematoma	facial injury	laceration
skull fx	mandible fx	contusion

X-ray: (Read by: __ E.P. __ Rad.)

1—☐_____ __nl 2—☐_____ __nl

3—☐_____ __nl 4—☐_____ __nl

Treatment / Mngmt Options / Course:

Medications / Orders **Response**

__ O2 at: __ IV of:
__ Tetanus: *dT .5ccIM / TIG*
__ Pain meds:
__ Antibiotics

Medical Decis. Making: *L1: straightforward; L2-3: low/complex; L4: mod; L5: hi*
Stash box if ordered ☑, check normals ✓, circle and note abnormals

Lab:

☐ CBC: __ *nl* __ *nl except:*
Hct ____ Hb ____
WBC ____
Segs ____ *Bands* ____ *Monos* ____
Lymphs ____ *Eos* ____

☐ Chem: __ *nl* __ *nl except:*
NA ____ *K* ____ *Glu* ____
Cl ____ *CO2* ____ *Anion gap* ____
BUN ____ *Creat.* ____

☐ ETOH ☐ Drug screen
☐ PT, PTT, INR
☐

☐ ABG: *on* __ *RA / O2:* ____ *% / L*
pH: ____ *PO2* ____
PCO2 ____ *HCO3* ____

☐ P. Ox __ *%: on* __ *RA / O2:* __ *% / L*
__ *nl / hypoxic*

☐ **EKG:** __ *NSR* __ *nl intervals*
__ *nl QRS* __ *nl ST-T waves*
Compared to: ____
__ *unchanged / changed*

Read by: __ *E.P.*
☐ Cardiac monitor: __ *NSR*

Wound Repair:

Location	Length / Depth	Repair
1)	1.5 cm superfic. / SQ / IM	Dermabond / staples 4 # of 4-0 Ethil
2)	____ cm superfic. / SQ / IM	Dermabond / staples ____ # of ____-0 ____

Comments:

1 sensat. intact 1 vasc. intact
Level of contamination: 2 *clean / min / mod / severe*
Anesthesia: *local / digital block* ____ cc of ____ *c epi / HCO3*
prep Suture removal instruct: ____ days
Explored no F.B. / F.B. identified
irrigat. debrided ___ undermined revised F.B. removed
(circle above: min = 1, mod = 2, extensive = 3)

Procedure: *see addendum:* ____
Critical Care: ____ minutes
Course: *same / better / worse*

Consultation / Other data reviewed:

Consulted Dr. ____ *(time)* ____
Suggests: *admit / discharge / will see:* ____
Case discussed with: *patient / family / other:*
Reviewed / discussed with Radiologist:
Reviewed: *NH / EMS / RN / Old Records / PL Quest.*

Clinical Impression:

1.5cm L.

Disposition:

1 home ___ admit: *ICU / monitor / OR / med. / surg.*
___ transfer to:
Admit physician:
Condition: *better / worse / stable / expired*
Instructions given: ___ *written* ___ *verbal*
Follow up: __ PMD / other: ____ in ___ days / prn / as scheduled
Restrictions: (__ *all work* __ *mild. duty* __ *gym* __ *school)* __ *days*
Discharge Rx: 5

Sig: ____ date ____ Attend. / Resid. / PA / NP
____ date ____ Attend. / Resid. / PA / NP

See: ___ Addendum ___ Attending note
Copies to:
☐ dictated
☐ chart completed

DEF-00190

E.R. 30018094
DAHL DOYLE M 40
002232 07/16/67
03/31/08 ZAHERI K

Head / Facial Injury #38

HANCOCK MEDICAL CENTER, BAY ST. LOUIS, MS 39520
Check (✓) for normals, circle positives, slash negatives, note findings

Date: _____ E.P. time: _____ Age: _____ Wt: _____ Sex: M / F
P: _____ BP: _____ / _____ RR: _____ Temp: _____

Referred by: *self / clinic / PMD / family / EMS* _____
Arrived by: *EMS / walk-in / wheelchair* _____
Historian: *patient / family / friend / EMS* _____
Hx limited by: *Altered LOC / acuity / intoxication*

Chief Complaint: LAC forehead

HPI: *L 1-3: 1-3 elements; L 4-5: 4+ elements*

Onset: __ undetermined
Occurred: _____ time _____ date
_____ *mins / hrs / days PTA*

In ER

Locale:
home / work
Other: EVL

Activity / Mechanism of injury:
unknown / found down
fell / fight / alleged assault
MVA / stab wound / GSW / burn:

Injury description (quality):
deformity / laceration / scratch / abrasion / puncture / bite / F.B. / burn
blunt trauma / contusion
penetrating trauma

Modifying Factors:
witnessed / unwitnessed
ambulatory at scene
spinal immobilization
Factors: *ETOH / drugs / seizure / syncope / suicidal attempt*
other:

Assoc. sxs: __ none
Headache:
Onset:
Course:
nausea / vomiting
LOC: *none / unknown / dazed / +LOC*
Duration: _____ sec / mins / hrs
Remembers: incident / coming to hospital
GCS: _____ / 15
Bleeding: *nose / ears / mouth / face / scalp*
Discharge: *nose / ears*
vertigo / lightheaded / weak / fainting
seizures / behavior change
focal deficits / amnesia (retrograde / anterograde)
neck pain

Prior Rx: __ none
EMS: *Spinal immobilization*
Other:

Location (anatomic):

ϕ LOC
ϕ neck pain

Past, Family, Social History: *L 1-3: 1 area; L5: 2 of 3 areas*

PMH: (none) __ unknown
prior head trauma
ETOH or drug abuse
psych probs
hypertension / CAD / CVA /
NIDDM / IDDM

Meds: __ none __ see RN note
ASA / NSAIDs / coumadin
insulin / steroids

Allergies: ___ see RN note
Tetanus current: ___ *yes / no*

Surgical Hx: __ none __ unknown
brain surgery
previous trauma

Family Hx: __ none __ unknown
seizures / aneurysms

Social Hx: __ unknown
Tobacco: _____ *ppd* _____ *yrs*
current: __ *no / yes*
ETOH: _____ *drinks / wk*
Recent? _____
Drugs:
Occupation:
Home situation: *lives alone*

Physical Exam: *L 2-3: 2-4 organ/areas; L4: 5-7 organ/areas; L5: 8+ organ/areas*

__ Exam limited by: *urgency of condition / pt. uncooperative*
Gen: Anxious: __ *no / mild / mod / severe* Distress: __ *no / mild / mod / severe*
__ VS nl Orthostat. VS: O—: _____ A: _____
Nutritional status: __ *nl / obese* Hydration: __ *nl / dehydrated*
Longboard / cervical immob. (ED / EMS) / IV / intubation / splint

Head / Neck (MS):
__ head & trauma / skin nl
__ neck & lend. ROM full

Eyes:
__ PERRL
__ lids, conj. nl
__ EOM's full
__ cornea, chambers, discs nl

ENT:
__ nose nl
__ ext. ears, canals, TM's nl
__ mouth, teeth, oropharynx nl
__ TMJ's nl; jaw ROM nl

CV:
__ reg rate, rhythm
__ heart sounds nl

Resp, Chest:
__ no resp distress
__ breath sounds nl, clear, equal

Spine / Pelvis / Ribs (MS):
__ thorac., lumbar inspect., palpat. nl
__ pelvis stable, inspect., palpat. nl
__ ribs stable, inspect., palpat. nl

GI / Abd / Flank:
__ abd nl appearance, BS nl
__ soft, nontender
__ flank nl appearance, nontender
__ rectal nl, heme neg

GU, Male:
__ ext. genit. nl
__ testic. nl

GU, Female:
__ ext. genit. nl
__ cervix nl, no discharge
__ uterus, uterus nl

MS:
__ ROM nl without pain
__ joints nl, no muscle tenderness
__ strength, tone nl

Skin:
__ no rash, lesions
__ warm & dry

Neuro:
__ alert & oriented x 3
__ motor, sensory nl
__ reflexes intact, symmetrical
__ Cranial nerves 2-12 intact
__ no ataxia

Psych:
__ affect, mood nl
__ judgment, memory nl

Lymph:
__ no adenopathy

Glasgow Coma Score _____
Eyes open: 4-spontaneous 3-to command 2-to pain 1-none
Verbal: 5-nl 4-confused 3-inappropriate 2-incoherent sounds 1-none
Motor: 6-normal 5-localizes pain 4-withdraws 3-decorticate (flex.) 2-decerebrate (ext.) 1-none

(phys. exam cont., p. 2)

ROS: *L 1-4: 1 system/pert. prob; L4: 2-9 systems; L5: 10+ systems*

All systems reviewed: ___ *negative* ___ *negative except as marked*

__ Constit: *fever / chills*
__ Eyes: *eye trauma / diplopia / blurred vision / loss of vision*
__ ENT: *hearing probs / epistaxis / dental trauma / oral trauma / malocclusion*
__ CV: *chest discomfort / palpitations*
__ Resp: breathing probs / cough
__ GI: *abdominal discomfort*
__ GU: urinary probs / kidney probs
LMP: _____ *nl / abnl*

__ MS: painful areas:
__ Skin: skin probs
__ Neuro: *numbness / tingling / incontinence / gait disturbance / prior seizures*
__ Psych: stress / anxiety / sleep probs
__ Hemat / Lymph: bruising / bleeding
__ Endo: polyuria / polydipsia
__ Immun / Allerg: *HIV / AIDS:*
call# ___ Viral load ___

Sister Arleen Power of Attorney
216-0137

HANCOCK medical

EMERGENCY DEPARTMENT NURSING RECORD

Name: Dahl, Doyle

Date: 3-31-08 Time: 0304 Triage Status: I II (III) IV

Mode of Arrival: (Ambulance) Walk Carried WC

Accompanied by: Alone Spouse Parent Friend (Other) Police

Age: 40 Sex: M Private MD: NLMD Weight: ≈180#

Allergies: Medicines: NKDA Substances: Ø

Advance Directives: ☑ Yes ☐ No Where ____ Occupation ____

Tetanus Status >5 yr (<5 yrs) Unk. Use of Alcohol Y (N) Use of Drugs Y (N) Tobacco (Self, Household) (Y) N ppd 1 can/day

Family Support / Family HX: Yes Cardiac DM HTN CA; Lives alone; Homeless; At risk for abuse or neglect; Other

"Chief Complaint"/Mechanism of Injury/Onset: c/o [illegible] and tased by police. Also c/o (Rt) shoulder pain. [illegible] to (Rt) [illegible] [illegible] (L) [illegible] area. Pt stated he was shocked in chest. Pt stated "[illegible] with it [illegible]"

Pain Scale: 0 1 2 3 4 5 6 7 8 (9) 10

Dull Sharp Ache Constant Intermittent Onset ____ Radiating ____

Treatment Prior to Arrival: None O_2 IV Collar/Immob. Other

Tx at Triage: Ice Elevation Splint Sling (Dressing) None Other

Were you injured at work? Y N Unscheduled ED < 48 hr ☐ yes ☐ no

Time of reassessment at Triage > 1 Hr.

Medical History: Seizure, (Psychiatric), Diabetes, Cardiac, Tuberculosis, (Pulmonary), (HTN), Hepatitis, Migraines, HIV, Asthma, Cancer, Renal, Sickle Cell, Other

Surgeries: T&A Appy GB Back Cataracts

Other: GSW [illegible] Nov 2007

Vital Signs Time	T	P	Resp.	BP	SpO_2	CBG
0308	97.7	104	18	171/113	95%	
0345		102	18	166/101	95%	

Medication	Dose	Frequency	Last Dose
Lexapro	10mg	daily	3-30-08
Atenolol	25mg	daily	3-30-08

INITIAL NURSING ASSESSMENT

Airway: ☑ Effective ☐ Ineffective
Breathing: ☑ Normal ☐ Labored
Breath Sounds: ☐ Clear ☐ Wheezing ☐ Diminished
Circulation / Skin Color: ☑ WNL ☐ cyanotic ☐ pale ☐ flushed ☐ jaundiced
Temperature: ☑ warm ☑ dry ☐ cool ☐ diaphoretic

Capillary Refill: ☑ < 3 seconds ☐ > 3 seconds
Mucous Membrane: ☑ pink ☑ moist ☐ pale ☐ tacky
Mental Status: ☑ Alert orientation ☑ person ☑ place ☑ time ☐ confused ☐ lethargic ☐ anxious ☐ unresponsive ☐ Δ in M.S.
GCS yes no
Bilateral Grips: ☑ NA ☐ equal ☐ weak R L

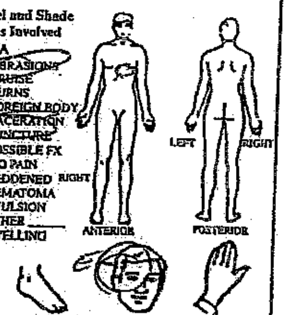
Cardiac: ☑ Denies Chest pain ☐ Dull ☐ Sharp ☐ Epigastric ☐ Radiating ☐ Non-radiating ☐ Substernal accompanied by ☐ SOB ☐ diaphoresis ☐ nausea
Cough ☑ Denies ☐ Productive ☐ Non-Productive
Eyes ☑ Denies Visual Acuity OD__ OS__ OU__

GI: ☑ Denies ☐ Nausea ☐ Vomiting X__ ☐ Diarrhea X__ ☐ Last BM__ ☐ Bleeding ☐ Emesis ☐ Rectum
Abd ☑ soft ☐ tender ☐ rigid ☐ distention ☐ rebound

OB/GYN: ☑ NA LMP__ Could you be pregnant? ☐ Yes ☐ No ☐ Hysterectomy FHT__ GR__ PARA__ AB__ ☐ Denies ☐ Vag d/c ☐ Vag bleeding ppd__
Urological: ☑ Denies ☐ Frequency ☐ pain, burning ☐ incontinence ☐ retention ☐ hematuria ☐ nocturia ☐ foley ☐ fever ☐ Discharge ♂

Extremities: ☑ Denies C/O Location__ Pain__ Pulse__ Pallor__ Paralysis__ Paresthesia__
Laceration: ☐ NA Size 1.5 cm Appearance__ Location__ Bleeding ☐ Active ☑ Controlled

Label and Shade Areas Involved
☐ N/A
A - ABRASIONS
B - BRUISE
C - BURNS
D - FOREIGN BODY
E - LACERATION
F - PUNCTURE
G - POSSIBLE FX
H - C/O PAIN
I - REDDENED
J - HEMATOMA
K - AVULSION
L - OTHER
M - SWELLING



Triage Nurse: [signature] RN

INFANT < 2 ☑ NA

Wet Diapers X__ in 12 HRS. Voided Last__

Crying/Quality	Hydration/Mucous Membrane	Color	Activity Level	Fontanels
Strong/Normal	Moist	Pink	Playful	Flat
Whimpering	Dry	Pale	Fussy	Bulging
Moaning/High-pitched	Poor Skin Turgor	Cyanotic	Quiet	Sunken

Immunizations Due By Hx ☐ UTD By Hx ☐
Head Circumference (as ordered)__
Birth Weight__

IV

Time	Amt./Soln	Rate	Site	Needle	Init	Amt. Infused	Time D/c'ed	Cath Intact	Init

Medications

Time	Medication	Amount	Route	Site	Init	Outcome
0340	Neosporin Oint	0.9gm	Top		[initials]	

Nurse's Notes Time to ER: 0304 O_2 @__ CM @__
To room [illegible] [illegible] TW. (0325) Exam per Dr. [illegible] completed. [illegible] (Rt) [illegible] [illegible] per Dr. [illegible]. TW

Nursing discharge instructions: (0340) Return as needed. Follow up [illegible] [illegible], [illegible] in 10 days.

Prescriptions Listed: Ø

Accompanied by: alone spouse parent friend (other) police officer
Pt outcomes ☐ unchanged ☑ improved ☐ Pain Scale __/10
Notifications/Time: Police__ DSH__ Clergy__ Coroner__ SS__ Funeral Home__
Nurse's Initials / Signature: [signature]

Reviewer's Initials ____

Nursing Diagnoses:
☐ Alt in Comfort
☐ Cardiac Output, Decreased
☐ Gas Exchange Impaired
☐ Potential Injury, potential
☐ Skin Integrity Impaired
☐ Trauma
☐ Breathing Patterns, Ineffective
☐ Fluid Volume, Alterations in.
☐ Hyperthermia (Fever) ☐ Infection, Pain
☐ Mobility, Impaired ☐ Tissue Perfusion, Alt in
☐ ____